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Foreign Health Sector Capacity Building and the U.S. Military

Col Edwin K. Burkett, USAF MC

ABSTRACT The U.S. joint military medical community has an increasing role in collaborative health sector engagement internationally as part of a whole of government approach to successful operations. The military must master the ability to catalyze health sector gains that can be developed by hosts, U.S. Government, and international agencies in both permissive environments and conflict zones. Capacity building is helping a partner develop their own capabilities, standards, and resources to the point of self-sufficiency. Optimal effects will come through understanding the military and civilian health sectors of nations and regions, grasping the importance of health to stability and security, and integrating efforts with global health initiatives. The goal is to cultivate military and civilian relationships that assist host nation-led sustainable health sector effects that result in enduring positive U.S. national security outcomes.

"If you give a man a fish he will have a single meal.
If you teach him how to fish, he will eat all his life."

—attributed to Kuan-tzu (Chinese Philosopher)

"If you plan for a year, plant a seed.
If for ten years, plant a tree.
If for a hundred years, teach the people.
When you sow a seed once, you will reap a single harvest.
When you teach the people, you will reap a hundred harvests."

—attributed to Kuan-tzu (720–645 BC).[1]

THE HEALTH SECTOR IN OPERATIONS

In order to have success in operations as part of a 3D (Diplomacy, Development, and Defense) strategy,[2] the joint health community must define and understand the two health sector components in which the U.S. military will have impact in a foreign country—the security health component and the civilian health component. For clarification purposes, the term "security" will refer to military, police, and paramilitary forces of our partners. In addressing these sector components, there are several health support tasks that joint health forces must accomplish—prevention of disease nonbattle injury called force health protection,[3] casualty care, security sector health engagement, and Medical Civil-Military Operations (MCMO). Significant challenges exist in defining objectives, measuring impact, and determining the levels of effort needed to achieve success in planning and executing health engagement.

Joint surgeons must use host nation (HN) partners, the National Center for Military Intelligence, nongovernmental organizations (NGOs), United Nation's World Health Organization, and other sources of information to gain a comprehensive understanding of the security and civilian components of a nation's health sector. Assessment must include the human resources, economic resources, logistics, facilities, and the existing plans and vision of the political and health sector leadership of the country. Digesting this information will enable health activities that assist the HN in strengthening capabilities that realistically suit their resources and needs. Baseline assessment is also a key step to designing objective-driven indicators that measure mission success. Synthesizing this complex milieu of information into a common operating picture is akin to the "operational art" applied by a commander for a successful campaign. The leader uses experience, intuition, facts, and expert advice in conjunction with doctrine to best define and accomplish objectives. There can be a common approach, but the uniqueness of each partner country and environment will dictate the artistic variations of the execution.

Variance between health systems may come from multiple factors. Health of individuals and populations are affected by the education, skill, and proportion of physicians and health workers; many countries are challenged by health worker shortages and other deficiencies. Transportation infrastructure and affordability may also hinder access to the health services causing people to forego doctor visits and treatments. Cultural norms, traditions, and public policy may inhibit health access for women, children, ethnic, or religious groups. Also, one country may have a strong security health system, whereas another may have minimal assets and sparse knowledge of expeditionary medical support and need greater emphasis on developing these capabilities. Another country may provide security personnel their health care through primarily civilian sources.

Strong relationships are critical in order to assist HN security forces to improve or establish capacity and capability that suit their missions and resources. Acute care of combat casualties, patient movement systems, medical logistics, and professional development are key components of success. Positive perception of these capabilities within security forces can improve health outcomes, enhance morale and confidence, and bolster line operator and medic relationships.[4] Respect for leadership and the mission may both be enhanced

929 Country Club Boulevard, Chesapeake, VA 23322.

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14. ABSTRACT
The U.S. joint military medical community has an increasing role in collaborative health sector engagement internationally as part of a whole of government approach to successful operations. The military must master the ability to catalyze health sector gains that can be developed by hosts, U.S. Government, and international agencies in both permissive environments and conflict zones. Capacity building is helping a partner develop their own capabilities,standards, and resources to the point of self-sufficiency. Optimal effects will come through understanding the military and civilian health sectors of nations and regions, grasping the importance of health to stability and security, and integrating efforts with global health initiatives. The goal is to cultivate military and civilian relationships that assist host nation-led sustainable health sector effects that result in enduring positive U.S. national security outcomes.

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by this attention to health issues. Synergy among partners is essential to determine the needs and preferred direction of the HN and likewise to a true increase in HN security force medical capacity. Joint leaders must identify the different goals and requirements of the military vice the civilian health systems in order to judge how U.S. military health forces should engage with the civilian aspects of the health sector. In a nonpermissive environment, the U.S. and allied military health forces may have greater responsibility for dealing with both health systems. The U.S. Department of State and the U.S. Agency for International Development (USAID) may defer their typical lead roles in stability operations until appropriate levels of security allow otherwise.[5,6] The U.S. military needs to grow expertise in health diplomacy and health sector development in order to make better decisions, accomplish tasks more efficiently, and transition appropriate programs to civilian *U.S. Government* (USG) or host control for sustained long-term impacts.

U.S. strategy is now emphasizing building partner capacity to support U.S. forces in contingency operations and to aid the partner's civilian health sector component in response to potential pandemics, national disasters, and complex emergencies. HN ownership of pertinent capabilities is the ultimate answer; and U.S. health forces need to serve as part of the collaborative to attain this goal; whether in peacetime security cooperation, disaster response, or the complex emergency involving armed conflict. "Once peace has been restored, the hard work of post-conflict stabilization and reconstruction must begin. Military involvement may be necessary to stop a bloody conflict, but peace and stability will last only if follow-on efforts to restore order and rebuild are successful. The world has found through bitter experience that success often depends on the early establishment of strong local institutions. . . ."[7] Public health, patient care systems, and other entities compromising the health sector are some of these critical local institutions. "In reality, however, the reconstruction effort cannot wait until peace is fully restored but rather is necessary to lay basic foundations for restoration even as security is tenuous and peace is being forged. In fact, this phase of reconstruction is an element that may enhance security efforts especially in counterinsurgency (COIN) operations where the population is influenced by the faction who can best meet their basic needs. In a COIN operation . . . the center of gravity is the will and ability to provide for the needs of the population 'by, with, and through' the HN government."[8]

CATALYZING AND SUPPORTING CAPACITY BUILDING

"Capacity building" is defined as "the transfer of technical knowledge and skills to individuals and institutions so that they acquire the long-term ability to establish effective policies and deliver competent public services."[9] Transfer of knowledge and skills is primarily done through education, training, advising, and mentoring. One major challenge in many developing countries may be emphasizing hands-on mentoring to unskilled health workers when illiteracy may be a huge barrier compounded by the language difference. HN ownership will spur innovative techniques to transfer technical knowledge in appropriate ways culturally and educationally. U.S. joint medical forces must approach foreign health system capacity building in the same "see one, do one, teach one" mentality that we use to train our medical professionals. First you watch an expert perform a task, then you do it under expert supervision, and then you teach someone else which solidifies your own capability.

Capacity building as described in joint doctrine,[10] and in the health sector, will include interventions that enhance indigenous capability and ownership. Health engagement should avoid providing prolonged health services that foster different population expectations than the HN can sustain in either their military or civilian systems. An important area for media scrutiny is the western tendency to build facilities without apparent regard to the personnel, logistical resourcing, knowledge, and technical expertise required for maintenance when the western elements depart, as described in an article criticizing Iraq reconstruction operations.[11] Health sector construction that does not fit into the established capacity building definition is prone to backfire. A potential preferred solution would be to embed experts with HN elements to assist them in building what they need in accordance with their plans and standards. This can only happen if U.S./Coalition forces involved work with the HN to develop realistic expectations and achievable goals. Additionally, health sector planning must use a development time frame measured in decades rather than the end of a short peacetime operation or a 12-month rotation in a conflict zone.

Security sector capacity building is one of six key mission areas for the Department of Defense[12] and is fundamental to both warfighting and noncombat stability tasks. The challenges to effective capacity building are not just inflexibility and unresponsiveness, but also aligning USG roles and missions to reflect how vital building partner capacity is for America's defense. Combatant Commanders have been directed to address security challenges that require building partner capacity; such efforts can also generate substantial dividends for U.S. security in all regions. In Colombia, for example, a robust U.S. capacity building effort has weakened antigovernment insurgents, helped free captive Americans, and promoted stability in the Western hemisphere. A major part of this fundamental task is helping to equip partner medical forces to provide sustainable, critical comprehensive health support to their military forces in garrison and in contingency operations in all theaters.

Civilian health sector capacity building should focus on public health and preventive medicine. The most common causes of morbidity and mortality are addressed through sanitation, accessible potable water, and the availability of nutritious food. Direct medical care and ancillary health

services have a role, and the U.S. military medical forces can partner with other agencies to deliver these services as needed. However, the need to focus on sanitation services, water treatment, and basic indigenous primary care capacity and access cannot be overemphasized. In a predominantly agrarian society, simple veterinary services such as herd health techniques for livestock and crop rotation ideas may preserve life and stimulate the economy. Important components within the health sector of a country include health system workers and leaders as well as the economics, infrastructure, and logistics. Each of these components must be considered and catalyzed in a building block fashion. Assisting the development of sustainable capacity for an adequate sewer, waste disposal, and clean water system is necessary before building hospitals.

Joint Forces Command's white paper, Emerging Challenges in Medical Stability Operations,[13] discusses a "preserve, enhance, restore, fulfill, transition" approach that is a good construct to guide planning for partner capability and capacity development. Perhaps the most critical part of the preservation phase is retaining and attracting HN health professionals and workers within their own health system and not contributing to the "brain drain" that typically occurs worldwide.[14] Preservation of staff begins with physical security when a conflict zone is involved because the risk of intimidation attack is a major obstacle. However, preservation of critical human capacity also means allowing health professionals to work in their fields rather paying them more for translator skills than for their profession. NGOs have committed similar errors and drained professionals from their professions within their own systems. Preservation means enabling entrepreneurial incentives for health sector growth that attracts indigenous professionals to build instead of creating parallel medical system that competes with local health providers. Planning for full HN control through a logical transition of health services requires coordination with health sector entities, such as USAID, NGOs, and the international health community. Transition thinking must begin with the earliest plans and the other principles of reconstruction,[9] including capacity building.

The U.S. military is an instrument of U.S. political interests; thus, involvement in a foreign health sector is a political act. However, this fact does not negate the inherent altruism of military health personnel or the health motto of "prima non nocere" (first do no harm). Good medicine, attention to common sense health basics, and capacity in public health can be accomplished while executing joint operations. Assisting a HN in building equitable health capacity builds trust in the HN government and contributes to peace, stability, and security. In fact, the capacity building approach in both the security and civilian health sector may have the best political outcomes and cost-effectiveness; but this has yet to be proven.

Future innovation in capacity building will involve collaboration between U.S. joint health forces, the USAID, the U.S. Department of Health and Human Services, and other U.S. and international health sector agencies. Methods to achieve capacity building include expansion of embedded subject matter experts into HN health systems as appropriate; codevelopment of self-sustaining training and education programs; enabling local care givers to serve the needs of displaced populations; and enhancing optimization of logistics and materiel management, finances, and governance processes.

The "teach a man to fish" proverb that is quoted at the beginning of this article is only partially applicable in medical stability operations. In fact the nations that invite U.S. military and other international assistance have some experts with the knowledge and skills "to fish" at a world class level and actually know the "water ways" of their own systems better than outsiders; the leaders may have some western training and they do not need to be taught to fish but rather assisted in mending their nets, becoming more efficient, and developing their apprenticeship programs to produce more "fishermen" of their own caliber. Expectations must be tempered by the realities of our own imperfect western health systems; seeking to build perfection elsewhere is an impossibility.

DIPLOMACY AND HEALTH

"Global health diplomacy" is a relatively new term intended to refine the historical use of comprehensive USG health assets to improve international relationships. "Health Diplomacy occupies the interface between international health assistance and international political relations. It may be defined as a political change agent that meets the dual goals of improving global health while helping repair failures in diplomacy, particularly in conflict areas and resource-poor countries."[15] Department of State is the diplomacy lead for the USG; however, military personnel, USAID representatives, and other agencies also present a diplomatic message through actions and interactions. Synergistic planning with the U.S. Ambassador's country team is required to ensure that medical forces portray the consistent themes of the U.S. diplomatic message and support to partners.

MILITARY HEALTH CAPABILITIES AND ENGAGEMENT

Within the Defense side of the 3-D triangle, military medical capabilities are employed internationally via a variety of health engagements. "Health engagement" may be defined as the routine contact and interaction between individuals or elements of the joint health forces of the United States and those of another nation's armed forces, or foreign civilian authorities or agencies to build trust and confidence, share information, coordinate mutual activities, and maintain influence.[16] It is through sustainable security health engagement and MCMO that joint health forces will assist allies and

partners in building the capacity necessary to aid in national and regional stability using a menu of existing and future U.S. capabilities.

U.S. joint doctrine discusses the role of health assets in civil-military operations, foreign humanitarian assistance,[17] other types of nation assistance, and overall medical efforts in support to noncombat activities.[18] However, neither the joint nor the service-specific doctrine lay out a standard strategic to tactical approach for application of health capabilities for global health diplomacy and foreign health sector capacity building. Health forces have historically engaged in direct health care to civilians, sometimes in conjunction with military counterparts but often as a sole provider. Short-term, direct activities do have some influence and may achieve some benefit depending upon the operational context, but they do not build capacity.

Three potential operational contexts for direct care include creating a receptive environment for other U.S. forces to maneuver, care given to neglected populations in peacetime or in disasters, and expert exchange done in side-by-side partnership with HN doctors/health workers. In the first context, a commander may need a short-term goodwill gesture to demonstrate or gain trust and gain cooperation of potential allies. Whenever possible, this type of activity should be rolled into a longer-term health strategy. Second, there are populations within countries that cannot access care despite government efforts or need access when HN services are overwhelmed in a disaster. Providing care, to include definitive surgeries, may have great humanitarian impact in the face of HN provider shortages, wait times, inability to pay even minimal cost, and patient travel limitations. Consider that the United States has about 40 million people without health insurance; their overall health status is better than some nations; however, a U.S. inner city population may likely respond to a direct care offering in similar numbers as a developing country. If this type of population is targeted, then it may be truly humanitarian with definitive outcomes and provide favorable messages for the HN and the United States although internal political benefit may be minimal because the people served have little power or influence. Third, if true partnerships are developed with HN health workers, then direct care can be given in the context of medical information exchange where two or more providers see a patient or address a health issue together and share knowledge and potential solutions. By design, this model would limit the number of patients potentially on a given day. Regardless, in any context, direct care must be considered with analysis and caution on a case-by-case basis because it is counter to HN medical continuity and may hinder capacity building, and the long-term impacts on the whole health sector have not been measured.[19,20]

Both land- and ship-based foreign humanitarian assistance missions to include what are called Medical Readiness Training Exercises (MEDRETE) and Medical Civic Assistance Program (MEDCAP) activities are done frequently and in every geographic area of responsibility in peacetime and in combat zones. Despite decades of effort, the true impact, clinical safety, and long-term medical and political impacts are not well quantified or qualified. Clarifying the objectives of health engagement missions within the context of the commander's theater security cooperation plan and assigning appropriate indicators would change the implementation of the majority of these missions and increase their effectiveness. Different types of missions all contributing to HN health sector sustainable capacity will result in longer lasting positive outcomes for the U.S. national interests. In fact, the original MEDCAP program begun in Vietnam was a capacity building program run by the HN with U.S. medical personnel in advisory roles.[21] The program morphed into direct care activities provided by U.S. health forces and that is what people think of today when the term MEDCAP is used. Joint health forces may now collaborate with the HN and others to establish a health sector common operating picture that potentiates targeting of needs and sustainable expectations for the population. Objective-driven, outcome-based validation may be what is required for planners and decision makers to see that a capacity building approach is possible and must be the standard instead of the exception.

Recent operational forays with Embedded Training Teams (ETTs) and Provincial Reconstruction Teams (PRTs) are prime opportunities to employ solid health sector strategies that initiate capacity building. Team approaches to mentoring and reconstruction such as these may help forge strong relationships and prove to be valuable tools in global health diplomacy. The ETTs in Afghanistan were designed to build security capacity, but the concept could possibly be applied in noncombat zones where security cooperation rather than COIN is the primary focus. In parallel, PRTs combine military and civilian personnel in a team aimed at civil sector development. Ideally, the health personnel sent to PRT duties should have a combination of expertise in their medical field, knowledge of public health principles, knowledge of the HN health system, civil affairs aptitude, and diplomacy skills. Predeployment education and training innovation to ensure the capability of the medical personnel sent to perform these missions is essential to achieving desired outcomes. Again, the PRT concept, whether led by civilians or military personnel, in current or scaled-down forms, may hold future application for health engagement in other parts of the world and across the range of operations.

The Defense Institute for Medical Operations is another joint capability that is available globally and is requested by country teams to provide medical education to HN militaries in a variety of topics including disaster and emergency response skills. Real success has been accomplished in some instances with HN establishing their own similar training. One example, in a peacetime security cooperation setting, is the Chilean Combat Casualty Care Course (C4); initially, the U.S. military exported the course, but then over the subsequent 5 years the Chilean military built up their cadre and

now teach the course including students from neighbor countries. The U.S. military now only provides some funding and consultants; the final step will be transition of all programmatic planning and costs to the HN. The next frontier is for health engagement efforts to be measured and documented more effectively and linked with accepted international standards such as maternal and infant mortality; Millennium Development Goals; U.S. Global Health Initiative; Sphere Standards; or International Health Regulations, while still achieving commander objectives.

CONCLUSION

Capacity building in the health sector is not achieved by coalition or outside contractors providing direct indigent patient care, building multiple clinics and hospitals, digging wells, or providing western medical technology. Although direct patient care has its role in conflict, disaster response, educational exchange, and in fulfilling moral obligations to neglected populations, it should be delivered as the exception rather than the rule. Health sector capacity building must involve engaging HN health experts, financial experts, and engineers and many others to discuss, educate, train, mentor, and advise, so the country can grow its own personnel, systems, clinics, and hospitals to reasonable standards. Finding the balance will depend upon the country, the mission type, the security situation, and multiple variables. This is akin to and linked with the commander's operational art of arranging and balancing military activities of the joint force.[22] In the case of the health sector, leaning toward the capacity building side of the balance will be best for the long-term outcomes.

Modern operating environments dictate significant Department of Defense participation in development and diplomacy although USAID and the Department of State retain leadership in their respective domains. The joint medical community must be able to engage in collaborative health sector development, security, and MCMO activities in a cost-effective manner and with sustainable outcomes that meet mutual goals. This will involve planning based upon thorough assessments of the military and civilian health systems, understanding global health diplomacy, recognizing the utility of health engagement within theater security cooperation and national security policy, and adherence to the principle of transfer of knowledge and skills that the HN can perpetuate to enhance its own health capability and capacity. In the security sector the U.S. or coalition force might remain a constant partner or consultant to varying levels, whereas in the civilian sector HN ownership and sustainability is the goal. Future discussion is needed on further describing and redefining types of health engagement activities, the objectives that guide them, how to measure them in a joint operational context, and preparation of joint health professionals capable of consistently executing these missions. Efforts to master these current and future challenges will involve continued refinement of relationships between the joint health community, international partners, and U.S. interagency.

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REFERENCES

1. Guanzi Institute for management studies. Available at http://guanzi.org/guanzi/kuan_tzu.asp; accessed November 15, 2009.
2. Hillary Rodham Clinton, Secretary of State, Testimony before the Senate Appropriations Committee, Washington, DC: Opening Remarks on the President's FY 2009 War Supplemental Request, April 30, 2009. Available at http://www.state.gov/secretary/rm/2009a/04/122463.htm; accessed July 15, 2010.
3. Lieutenant General (Dr.) James G. Roudebush, Air Force Surgeon General: Presentation to the Committee on Armed Services Subcommittee on Military Personnel, United States House of Representatives, Army Medical Action Plan and Support for Wounded Service Members from Other Services, February 15, 2008. Available at www.sg.af.mil/shared/media/document/AFD-080215-046.pdf; accessed August 9, 2011.
4. Bricknell M, Thompson D: Roles for international military medical services in stability operations (security sector reform). J R Army Med Corps 2007; 153(2): 95–8.
5. Department of Defense: Instruction 3000.05, Stability Operations, September 16, 2009. Available at www.dtic.mil/whs/directives/corres/pdf/300005p.pdf; accessed July 15, 2010.
6. Department of Defense: Instruction 6000.16, Military Health Support for Stability Operations, May 17, 2010. Available at www.dtic.mil/whs/directives/corres/pdf/600016p.pdf; accessed August 9, 2011.
7. The White House: National Security Strategy of the United States, March 16, 2006. Available at http://georgewbush-whitehouse.archives.gov/nsc/nss/2006/; accessed August 9, 2011.
8. International Security Assistance Force, Kabul, Afghanistan: Commander's Initial Assessment, August 30, 2009. Available at http://media.washingtonpost.com/wp-srv/politics/documents/Assessment_Redacted_092109.pdf; accessed January 30, 2011.
9. Natsios AS: The nine principles of reconstruction and development. U.S. Agency for International Development. Parameters Autumn 2005, p 8.
10. Joint Publication 3-57, Civil Military Operations, July 8, 2008, Annex C, para 6. Available at http://www.dtic.mil/doctrine/jel/new_pubs/jp3_57.pdf; accessed June 1, 2010.
11. Williams T: US fears Iraq development projects may go to waste. New York Times. November 21, 2009.
12. Department of Defense: Quadrennial Defense Review Report, February 2010. Available at www.au.af.mil/au/awc/awcgate/dod/qdr2010feb01.pdf; accessed January 30, 2011.
13. US Joint Forces Command: Emerging challenges in medical stability operations white paper, October 2007. Available at http://mso. cdham.org/; accessed January 30, 2011.
14. Garrett L: The challenge of global health. Foreign Affairs. January/February 2007.
15. Centers for Disease Control (CDC), Division of Global Public Health Capacity Development. GHS Initiative in Health Diplomacy: 2002-2008. Available at http://globalhealthsciences.ucsf.edu/programs/Diplomacy.aspx; accessed December 1, 2009.
16. Modification of the definition of "military engagement" from Joint Publication 1-02, DOD Dictionary of Military and Associated Terms. As amended through March 17, 2009.

17. Joint Publication 3-29, Foreign Humanitarian Assistance, March 17, 2009. Available at http://www.dtic.mil/doctrine/new_pubs/jp3_29.pdf; accessed August 9, 2011.
18. Joint Publication 4-02, Health Service Support, October 2006. Available at http://www.dtic.mil/doctrine/new_pubs/jp4_02.pdf; accessed August 9, 2011.
19. Bonventre E: Monitoring and evaluation of department of defense humanitarian assistance programs, Mil Rev January–February 2008.
20. Drifmeyer J: Toward more effective humanitarian assistance. Mil Med 2004; 169(3):161–8.
21. Wilensky RJ: Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War, p 54. Lubbock, TX, Texas Tech University Press, 2004.
22. Chairman of the Joint Chiefs of Staff, Capstone Concept for Joint Operations, January 2009. Available at http://www.dtic.mil/futurejointwarfare/concepts/approved_ccjov3.pdf; accessed August 9, 2011.